Calendar No. 93

110TH CONGRESS *1st Session* | SENATE | REPORT 110–53

MENTAL HEALTH PARITY ACT OF 2007

APRIL 11, 2007.—Ordered to be printed

Mr. KENNEDY, from the Committee on Health, Education, Labor, and Pensions, submitted the following

R E P O R T

[To accompany S. 558]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 558) to provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill (as amended) do pass.

CONTENTS

I. PURPOSE AND NEED FOR LEGISLATION

The purpose of S. 558 "The Mental Health Parity Act of 2007" is to expand the Mental Health Parity Act (MHPA) of 1996 by ensuring parity for mental health benefits that goes beyond annual and lifetime limits. S. 558 does not mandate that group health plans provide any mental health coverage, but if a plan does offer mental health coverage, then S. 558 prohibits group health plans (or health insurance coverage offered in connection with a group health plan) from imposing financial requirements (including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits) or treatment limitations (including lim-

59–010

its on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope and duration of treatment) on mental health benefits that are more restrictive than the financial requirements or treatment limitations applied to medical and surgical benefits. Thus, the group health plan or coverage must ensure that the financial requirements or treatment limitations applied to mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits that the plan covers. It does not preempt State mandate laws that require coverage of mental health benefits.

Providing parity in mental health coverage is an urgent matter because of the fact that mental disorders are a leading cause of disability in the United States. Success rates for treatment of mental disorders often equal or surpass those for physical conditions. An estimated 26.2 percent of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year, which equates to 57.7 million people in the United States. The Mental Health Parity Act of 2007 would guarantee mental health parity to 87.4 million employees covered by self-insured plans and 31 million employees covered by insured plans.

Parity in mental health benefits is necessary because of the huge impact that mental illness and substance abuse has on our society. Mental illness and substance abuse results in significant lost productivity and absenteeism and accounts for over 15 percent of the burden of disease in the United States. Furthermore, it has been determined that mental illness and substance abuse cause more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis. The need for S. 558 is further substantiated by the fact that approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, which cost employers in the United States $17 billion each year. Investing in mental health parity is beneficial for the Nation because the costs associated with lost worker productivity and the costs of providing extra physical health services outweigh the costs of implementing parity for mental health treatment.

Additionally, it should be noted that a 2004 Department of Health and Human Services actuarial study of the impact of mental health and substance abuse parity on health plans under the Federal Employee Health Benefit Program (FEHBP) shows that utilization of services increased 15 percent from pre-parity levels, and yet the cost increase associated with parity was only 0.94 percent. S. 558 is, therefore, a fair solution to the injustices that people with mental illness experience while receiving treatment. It will save lives, increase the quality of life for group health plan participants suffering from mental illness, and save money.

II. SUMMARY OF LEGISLATION

The Mental Health Parity Act of 2007 (S. 558) is a comprehensive statute that incorporates several key provisions relating to mental health parity protections for group health plan participants that are consistent with the safe and sound operation of group health plans. It also includes, for the first time, a parity requirement for substance abuse.

S. 558 does not prohibit group health plans from negotiating separate reimbursement or provider payment rates and service delivery systems, or managing the provision of mental benefits in order to provide medically necessary treatments under the plan. S. 558 does, however, require that if a group health plan provides both medical and surgical benefits and mental health benefits (including substance abuse treatment), and provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), then the plan must ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits.

Individual plans and employers with 50 or fewer employees are exempt from the law.

Additionally, group health plans that can demonstrate that compliance with S. 558 increased their actual total costs of coverage under the plan may elect to be exempt from parity under this act for the following plan year if it is projected that the health plan will experience increased actual total costs of coverage under the plan that exceed 2 percent of the actual total plan costs during the first plan year or exceed 1 percent of the actual total plan costs each subsequent year. It should be noted that group health plans could not permanently opt out of complying with the parity requirement and that the exemption under this section only applies for one plan year. It should also be noted that an employer may still elect to continue to apply mental health parity even if it meets the threshold for cost exemption.

"Mental Health Benefits," means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the plan or coverage, and when applicable, as may be defined under State law to health insurance coverage offered in connection with a group health plan. This definition comes from the 1996 definition of the Mental Health Parity Act, with the exception of the portion pertaining to substance abuse treatment.

The provisions of this legislation relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supersede any provision of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of Section 712A.

Enforcement of this act follows the enforcement structure contained in the Mental Health Parity Act of 1996, which requires the Department of Labor, Department of the Treasury, and the Department of Health and Human Services to share enforcement jurisdiction.

In addition, this act requires DOL and DHHS to each ensure that random audits of health plans are conducted in order to determine compliance with this act. This act also requires both DOL and DHHS to designate an individual within each agency to serve as the ombudsman whose primary duties are to serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning their coverage of mental health services under group health plans.

III. History of Legislation and Votes in Committee

Congress enacted the Mental Health Parity Act in 1996 in response to the inequitable and unfair treatment afforded people with mental illness in their health care coverage. The original legislation established for the first time that group health plans could not treat mental illnesses differently from medical illnesses with regard to annual and lifetime limits on coverage. However, it soon became apparent that while this original legislation was a step in the right direction, the legislation failed to adequately address the continued inequities that persons with mental illness experience in their health care coverage. The Mental Health Parity Act of 2007 aims to address these inequities by prohibiting group health plans from imposing financial requirements or treatment limitations on the coverage of mental health conditions (including substance abuse) that are more restrictive than financial requirements and treatment limitations that are applied to medical and surgical benefits.

Notwithstanding its limited provisions, the Mental Health Parity Act of 1996 was a significant step forward in the advent of State mental health policy. In 1991, Texas and North Carolina became the first States to enact mental health parity legislation. The laws required health insurers that covered State government employees to provide equal coverage for mental and physical conditions. Prior to the enactment of the Mental Health Parity Act in 1996, five more States passed laws that required State-regulated group health plans to provide parity in mental health coverage. By 2001, 45 States had enacted some parity law. Today, there are 49 States in total that have some parity law.

A bipartisan bill, S. 558, was introduced on February 12, 2007 by Senator Domenici, Senator Kennedy, and Senator Enzi. The bill was referred to the Committee on Health, Education, Labor, and Pensions. S. 558 was brought up for markup at the Health, Education, Labor, and Pensions Committee Executive Session on February 14, 2007. At that time, Senator Harkin offered an amendment by Senator Dodd, which included a technical change to clarify provisions relating to the GAO study. This amendment required GAO to examine and report on "the impact on out-of-network coverage for mental health benefits (including substance abuse treatment)." The amendment was adopted by unanimous consent and the bill was favorably reported to the full Senate by a vote of 18–3.

IV. Cost Estimate

S. 558—Mental Health Parity Act of 2007

Summary: The Mental Health Parity Act of 2007 would prohibit group health plans and group health insurance issuers that provide both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements for coverage of mental health benefits that are different from those used for medical and surgical benefits.

The bill would affect both Federal revenues and direct spending for Medicaid, beginning in 2009. The bill would result in higher premiums for employer-sponsored health benefits. Higher premiums, in turn, would result in more of an employee's compensa-

tion being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages. As a result of this shift, Federal income and payroll tax revenues would decline. The Congressional Budget Office (CBO) estimates that the proposal would reduce Federal tax revenues by $1 billion over the 2009–2012 period and by $3 billion over the 2009–2017 period. Social Security payroll taxes, which are off-budget, would account for about 35 percent of those totals.

The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting S. 558 would increase Federal direct spending for Medicaid by $280 million over the 2009–2012 period and by $790 million over the 2009–2017 period. In addition, assuming appropriation of the necessary amounts, CBO estimates that implementing S. 558 would have discretionary costs of $20 million in 2008, $143 million over the 2008–2012 period, and $322 million over the 2008–2017 period.

S. 558 would preempt State laws governing mental health coverage that are different than those in this bill and that apply to firms with 50 or more employees. That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). However, because the preemption only would prohibit the application of State regulatory law, CBO estimates that the costs of the mandate to State, local, or tribal governments would not be significant and thus would not exceed the threshold established by UMRA ($66 million in 2007, adjusted annually for inflation).

As a result of this legislation, some State, local, and tribal governments would pay higher health insurance premiums for their employees. However, these costs would not result from intergovernmental mandates, but would be costs passed on to them by private insurers who would face a private-sector mandate to comply with the requirements of the bill.

The bill would impose a private-sector mandate on group health plans and group health insurance issuers by prohibiting them from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. Under current law, the Mental Health Parity Act of 1996 requires a more-limited form of parity between mental health and medical and surgical coverage. That mandate is set to expire at the end of 2007. Thus, S. 558 would both extend and expand the existing mandate requiring mental health parity. CBO estimates that the direct costs of the private-sector mandate in the bill would total about $1.5 billion in 2009, and would grow in later years. That amount would significantly exceed the annual threshold established by UMRA ($131 million in 2007, adjusted for inflation) in each of the years that the mandate would be in effect.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 558 is shown in the following table.

ESTIMATED BUDGETARY EFFECTS OF S. 558

	By fiscal year, in millions of dollars—											
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
CHANGES IN REVENUES												
Income and HI Payroll Taxes (on-budget)	0	-90	-160	-190	-210	-230	-250	-260	-280	-300	-650	-1,970
Social Security Payroll Taxes (off-budget)	0	-50	-90	-100	-110	-120	-130	-140	-150	-160	-350	-1,050
Total Changes	0	-140	-250	-290	-320	-350	-380	-400	-430	-460	-1,000	-3,020
CHANGES IN DIRECT SPENDING												
Medicaid:												
Estimated Budget Authority	0	60	70	70	80	90	90	100	110	120	280	790
Estimated Outlays	0	60	70	70	80	90	90	100	110	120	280	790
CHANGES IN SPENDING SUBJECT TO APPROPRIATION												
Implementation costs for DHHS and DOL:												
Estimated Authorization Level	25	30	30	30	35	35	35	35	35	40	150	330
Estimated Outlays	20	29	30	30	34	35	35	35	35	39	143	322

NOTE: DHHS = Department of Health and Human Services, DOL = Department of Labor, HI = Hospital Insurance (Part A of Medicare).

Basis of Estimate: This bill would prohibit group health plans and group health insurance issuers who offer mental health benefits (including benefits for substance abuse treatment) from imposing treatment limitations or financial requirements for those benefits that are different from those used for medical and surgical benefits. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits. The provision would apply to benefits for any mental health condition that is covered under the group health plan. The bill would not require plans to offer mental health benefits, nor would it require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments. Laws in some States, however, require that plans cover those benefits, which would affect the potential impact of this bill on health plan premiums.

Revenues: The provisions of the bill would apply to both self-insured and fully insured group health plans. Small employers (those employing between 2 and 50 employees in a year) would be exempt from the bill's requirements, as would individuals purchasing insurance in the individual market. The bill also would exempt group health plans for whom the cost of complying with the requirements would increase total plan costs (for medical and surgical benefits and mental health benefits) by more than 2 percent in the first plan year following enactment, and 1 percent in subsequent plan years. In general, S. 558 would preempt State laws regarding parity of mental health benefits. The bill would not affect the application of State law for firms with fewer than 50 employees. In addition, because State parity laws and the proposed Federal law are very similar, S. 558 would not have a significant impact on people already affected by State parity laws.

CBO's estimate of the cost of this bill is based in part on published results of a model developed by the Hay Group. That model relies on data from several sources, including the claims experience of private health insurers and the Medical Expenditure Panel Survey. CBO adjusted those results to account for the current and future use of managed care arrangements for providing mental health benefits and the increased use of prescription drugs that mental health parity would be likely to induce. Also, CBO took account of the effects of existing State and Federal rules that place requirements similar to those in the bill on certain entities. (For example, the Office of Personnel Management implemented mental health and substance abuse parity in the Federal Employees Health Benefits Program in January 2001.)

CBO estimates that S. 558, if enacted, would increase premiums for group health insurance by an average of about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums that would likely be charged under the bill. Those responses would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or sub-

stance benefits), and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher copayments. CBO expects that those behavioral responses would offset 60 percent of the potential impact of the bill on total health plan costs.

The remaining 40 percent of the potential increase in costs—less than 0.2 percent of group health insurance premiums—would occur in the form of higher spending for health insurance. Those costs would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that increase would ultimately be passed through to workers. State, local, and tribal governments are assumed to absorb 75 percent of the increase and to reduce their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the increase. CBO estimates that the resulting reduction in taxable income would grow from $2 billion in 2009 to $4.5 billion in 2017.

Those reductions in workers' taxable compensation would lead to lower Federal tax revenues. CBO estimates that Federal tax revenues would fall by $140 million in 2009 and by $3 billion over the 2009–2017 period if S. 558 were enacted. Social Security payroll taxes, which are off-budget, would account for about 35 percent of those totals.

Direct Spending: The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting S. 558 would increase Medicaid payments to managed care plans by about 0.2 percent. That is less than the 0.4 percent increase in the estimated increase in spending for employer-sponsored health insurance because Medicaid programs offer broader coverage of mental health benefits than the private sector. CBO estimates that enacting S. 558 would increase Federal spending for Medicaid by $280 million over the 2009–2012 period and $790 million over the 2009–2017 period.

Spending Subject to Appropriation: S. 558 would require the Secretary of Labor and the Secretary of Health and Human Services to each designate an individual to serve as ombudsman to group health plans, and would require the departments to conduct random audits of plans to ensure that they are in compliance with the requirements of the bill. Based on the costs of implementing the Health Insurance Portability and Accountability Act of 1996, and assuming appropriation of the necessary amounts, CBO estimates that implementing S. 558 would increase spending by $20 million in 2008 and by $30 million to $40 million annually in subsequent years.

Estimated Impact on State, Local, and Tribal Governments: S. 558 would preempt State laws governing mental health coverage that are different than those in this bill and that apply to firms with 50 or more employees. The preemption would be an intergovernmental mandate as defined in UMRA. However, because the preemption would simply prohibit the application of State regulatory law, CBO estimates that the mandate would impose no significant costs on State, local, or tribal governments.

An existing provision in the Public Health Service Act (PHSA) would allow State, local, and tribal governments, as employers that provide health benefits to their employees, to opt out of the re-

quirements of this bill. Consequently, the bill's requirements for mental health parity would not be intergovernmental mandates as defined in UMRA, and the bill would affect the budgets of those governments only if they choose to comply with the requirements on group health plans. Roughly two-thirds of employees in State, local, and tribal governments are enrolled in self-insured plans.

The remaining governmental employees are enrolled in fully insured plans. Governments purchase health insurance for those employees through private insurers and would face increased premiums as a result of higher costs passed on to them by those insurers. The increased costs, however, would not result from intergovernmental mandates. Rather, they would be part of the mandate costs initially borne by the private sector and then passed on to the governments as purchasers of insurance. CBO estimates that State, local, and tribal governments would face additional costs of about $100 million in 2009, increasing to about $155 million in 2012. This estimate reflects the assumption that governments would shift roughly 25 percent of the additional costs to their employees.

Because the bill's requirements would apply to managed care plans in the Medicaid program, CBO estimates that State spending for Medicaid also would increase by about $210 million over the 2008–2012 period.

Estimated Impact on the Private Sector: The bill would impose a private-sector mandate on group health plans and issuers of group health insurance that provide medical and surgical benefits as well as mental health benefits (including benefits for substance abuse treatment). S. 558 would prohibit those entities from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. The requirements would not apply to coverage purchased by employer groups with fewer than 50 employees. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits.

Under current law, the Mental Health Parity Act of 1996 prohibits group health plans and group health insurance issuers from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than limits imposed on medical and surgical coverage. The current mandate is set to expire at the end of calendar year 2007. Consequently, S. 558 would both extend and expand the current mandate requiring mental health parity.

CBO's estimate of the direct costs of the mandate assumes that affected entities would comply with S. 558 by further increasing the generosity of their mental health benefits. Many plans currently offer mental health benefits that are less generous than their medical and surgical benefits. We estimate that the direct costs of the additional services that would be newly covered by insurance because of the mandate would equal about 0.4 percent of employer-sponsored health insurance premiums compared to having no mandate at all.

CBO estimates that the direct costs of the mandate in S. 558 would be $1.5 billion in 2009, rising to $3.4 billion in 2013. Those

costs would exceed the threshold specified in UMRA ($131 million in 2007, adjusted annually for inflation) in each year the mandate would be in effect.

Estimate Prepared By: Federal Costs: Jeanne De Sa and Shinobu Suzuki. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Stuart Hagen.

Estimate Approved By: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

V. Regulatory Impact Statement

The committee has determined that there will be minimal increases in the regulatory burden imposed by this bill.

VI. Application of Law to Legislative Branch

The committee has determined that there is no legislative impact.

VII. Section-by-Section Analysis

Section 1. Short title

Section 1 specifies the title of the legislation as the "Mental Health Parity Act of 2007."

Section 2. Mental health parity

Section 2 amends ERISA.

Section 712A. Mental health parity

This section stipulates that a group health plan (or health insurance coverage offered in connection with such a plan) must ensure that the financial requirements that are applied to mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits that the plan covers, including:

1. deductibles,
2. copayments,
3. coinsurance,
4. out-of-pocket expenses,
5. and annual and lifetime limits.

Group health plans are not permitted under this section to establish separate cost sharing requirements that are only directed at mental health benefits.

The group health plan (or health insurance coverage offered in connection with such a plan) must also ensure that the treatment limitations applied to mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits that the plan covers, including:

1. limits on the frequency of treatment,
2. number of visits,
3. days of coverage,
4. or other similar limits on the scope or duration of treatment.

This section does not prohibit health plans from:

1. negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits or

2. managing the provision of mental benefits in order to provide medically necessary treatments under the plan (as a means to contain costs and monitor and improve the quality of care) or

3. taking into consideration similar treatment settings or similar treatments when applying the provisions of this section.

This section requires that if a group health plan provides both medical and surgical benefits and mental health benefits (including substance abuse treatment), and provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), then the plan must ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits.

This section does not require that a group health plan (or coverage) eliminate, reduce, or provide out-of-network coverage.

This section does not apply to any group health plan for any plan year of any small employer. Small employers are those who employ 50 or less employees. Determination of employer size for purposes of this act shall follow rules consistent with those the rules under section 414 of the Internal Revenue Code of 1986.

In order to determine whether an employer who did not exist throughout the preceding calendar year is a small employer, for the purpose of this section, it should be based on the average number of employees that the employer is reasonably expected will employ on business days in the current calendar year. It should also be noted that any reference to an employer in this section also includes a reference to any predecessor of the current employer.

A group health plan may elect to be exempt from parity under this act for the following plan year if it is projected that the group health plan will experience increased actual total costs of coverage with respect to medical and surgical benefits and mental health benefits under the plan that exceed 2 percent of the actual total plan costs during the first plan year or exceed 1 percent of the actual total plan costs each subsequent year. It should be noted that the exemption under this section only applies for one plan year and that an employer may still elect to continue to apply mental health parity even if it meets the threshold for cost exemption.

This section requires that a qualified actuary who is a member in good standing in the American Academy of Actuaries will determine the increases in costs under a plan. Such determinations shall be certified by the actuary and be made available to the general public.

This section stipulates that group health plans that desire an exemption for meeting the threshold for cost exemption can only do so after they have complied with this section for the first 6 months of the plan year involved.

If the plan elects to modify its coverage of mental health benefits, then it will be treated as a significant modification in the terms of the plan and will have to give appropriate notice to plan members when required.

This section should not be construed to require group health plans to provide any mental health benefits.

This section defines "Mental Health Benefits" to mean benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage.

Section 2705A. Mental health parity

The provisions of this section are identical to section 712A, but with the exception that Secretary under this section refers to the Secretary of Health and Human Services because this section pertains to the Public Health Service Act. Please see section 712A above for the analysis.

This section defines "Mental Health Benefits" to mean benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage, and, when applicable, as may be defined under State law to health insurance coverage offered in connection with a group health plan.

Section 3. Effective date

Section 3 stipulates that with respect to group health plans or health insurance coverage offered in connection with such plans—this law will take effect beginning in the first plan year that begins on or after January 1 of the first calendar year that begins more than 1 year after the date of the enactment of this Act.

This section also states that the effective date noted above does not apply to benefits for services that are furnished after the effective date noted above.

Section 4. Special preemption rule

Section 4 amends Section 731 of the Employee Retirement Income Security Act of 1974 to provide that the provisions of this act relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supersede any provision of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of Section 712A.

Nothing in this section should be construed to preempt State insurance laws relating to the individual insurance market or to small employers.

With respect to a State, this law will be effective the same date as it is effective with respect to group health plans. [With respect to group health plans this law must take effect beginning in the first plan year that begins on or after January 1 of the first calendar year that begins more than 1 year after the date of the enactment of this act.]

Section 5. Federal administrative responsibilities

Section 5 requires both the Secretary of Labor and the Secretary of Health and Human Services to designate a person within their respective agencies to serve as the group health plan ombudsman. The primary duties of the ombudsman is to serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning their coverage of mental health serv-

ices under group health plans or under health insurance coverage issued in connection with group health plans.

This section requires that the Secretaries of Labor and Health and Human Services each ensure that random audits of group health plans and health insurance coverage offered in connection with group health plans are conducted in order to determine whether group health plans are in compliance with this act.

This section requires the Comptroller General to conduct a study and prepare and submit a report within 2 years of enactment of this act to the appropriate committees of Congress, which evaluates the effect that the implementation of this Act has on:

1. The cost of health insurance coverage;
2. Access to health insurance coverage (including the availability of in-network providers);
3. The quality of health care;
4. Impact on benefits and coverage for mental health and substance abuse;
5. The impact of any additional costs or savings to the plan;
6. The impact on out-of-network coverage for mental health benefits (including substance abuse treatment);
7. The impact on State mental health benefit mandate laws;
8. Other impact on the business community and the Federal Government and,
9. Other issues as determined appropriate by the Comptroller General.

Except as otherwise provided in this act, enforcement of this act follows the enforcement structure contained in the Mental Health Parity Act of 1996, which requires the Department of Labor, Department of the Treasury, and the Department of Health and Human Services to share enforcement jurisdiction.

This section also requires the Secretaries of Labor and Health and Human Services to promulgate regulations within 1 year after the date that the act is enacted.

VIII. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

Subtitle A—General Provisions

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY

* * * * * * *

SUBPART B—OTHER REQUIREMENTS

SEC. 711. [1185] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

* * * * * * *

SEC. 712. [1185a] PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

(a) IN GENERAL.— * * *

* * * * * * *

[(f) SUNSET.—This section shall not apply to benefits for services furnished after December 31, 2006.**]**

(f) SUNSET.—This section shall not apply to benefits for services furnished after the effective date described in section 3(a) of the Mental Health Parity Act of 2007.

* * * * * * *

SEC. 712A. MENTAL HEALTH PARITY.

(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall ensure that—

(1) the financial requirements applicable to such mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the plan (or coverage) may not establish separate cost sharing requirements that are applicable only with respect to mental health benefits; and

(2) the treatment limitations applicable to such mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(b) CLARIFICATIONS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not be prohibited from—

(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);

(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; or

(3) applying the provisions of this section in a manner that takes into consideration similar treatment settings or similar treatments.

(c) IN- AND OUT-OF-NETWORK.—

(1) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, and that provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), such plan (or coverage) shall ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits.

(2) CLARIFICATION.—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or coverage in connection with such a plan) eliminate, reduce, or provide out-of-network coverage with respect to such plan (or coverage).

(d) SMALL EMPLOYER EXEMPTION.—

(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of any employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(e) COST EXEMPTION.—

(1) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connections with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health benefits under the plan (as determined and certified under paragraph (3)) by an amount that exceeds the applicable percentage described in paragraph (2) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan

year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(2) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

(A) 2 percent in the case of the first plan year in which this section is applied; and

(B) 1 percent in the case of each subsequent plan year.

(3) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

(4) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connections with a group health plan) seeks an exemption under this subsection, determinations under paragraph (1) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(5) NOTIFICATION.—An election to modify coverage of mental health benefits as permitted under this subsection shall be treated as a material modification in the terms of the plan as described in section 102(a)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

(g) MENTAL HEALTH BENEFITS.—In this section, the term "mental health benefits" means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage.

SEC. 731. [1191] PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—* * *

* * * * * * *

(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

(1) IN GENERAL.—* * *

* * * * * * *

(c) SPECIAL RULE IN CASE OF MENTAL HEALTH PARITY REQUIREMENTS.—

(1) IN GENERAL.—Notwithstanding any provision of section 514 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supercede any provision of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of section 712A.

(2) CLARIFICATIONS.—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual insurance market or to small employers (as such term is defined for purposes of section 712A(d)).

[(c)]*(e)* RULES OF CONSTRUCTION.—* * *

[(d)]*(f)* DEFINITIONS.—For purposes of this section—

(1) STATE LAW.—* * *

* * * * * * *

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—GROUP MARKET REFORMS

Subpart 1—Portability, Access, and Renewability Requirements

SEC. 2701 [300gg] INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

* * * * * * *

Subpart 2—Other Requirements

SEC. 2704. [300gg–4] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS

* * * * * * *

SEC. 2705. [300gg–5] PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

(a) IN GENERAL.—* * *

* * * * * * *

[(f) SUNSET.—This section shall not apply to benefits for services furnished after December 31, 2007.]

(f) SUNSET.—This section shall not apply to benefits for services furnished after the effective date described in section 3(a) of the Mental Health Parity Act of 2007.

* * * * * * *

SEC. 2705A. MENTAL HEALTH PARITY.

(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall ensure that—

(1) the financial requirements applicable to such mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the plan (or coverage) may not establish separate cost sharing requirements that are applicable only with respect to mental health benefits; and

(2) the treatment limitations applicable to such mental health benefits are no more restrictive than the treatment limitations

applied to substantially all medical and surgical benefits covered by the plan (or coverage), including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(b) CLARIFICATIONS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not be prohibited from—

(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);

(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; or

(3) be prohibited from applying the provisions of this section in a manner that takes into consideration similar treatment settings or similar treatments.

(c) IN- AND OUT-OF-NETWORK.—

(1) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, and that provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), such plan (or coverage) shall ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits.

(2) CLARIFICATION.—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or coverage in connection with such a plan) eliminate, reduce, or provide out-of-network coverage with respect to such plan (or coverage).

(d) SMALL EMPLOYER EXEMPTION.—

(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of any employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be

based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(e) COST EXEMPTION.—

(1) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connections with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health benefits under the plan (as determined and certified under paragraph (3)) by an amount that exceeds the applicable percentage described in paragraph (2) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(2) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

(A) 2 percent in the case of the first plan year in which this section is applied; and

(B) 1 percent in the case of each subsequent plan year.

(3) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

(4) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connections with a group health plan) seeks an exemption under this subsection, determinations under paragraph (1) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(5) NOTIFICATION.—An election to modify coverage of mental health benefits as permitted under this subsection shall be treated as a material modification in the terms of the plan as described in section 102(a)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

(g) MENTAL HEALTH BENEFITS.—In this section, the term "mental health benefits" means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage, and when applicable as

may be defined under State law when applicable to health insurance coverage offered in connection with a group health plan.

* * * * * * *

SEC. 2723. [300gg–23] PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—* * *

* * * * * * *

(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

(1) IN GENERAL.—* * *

* * * * * * *

(c) SPECIAL RULE IN CASE OF MENTAL HEALTH PARITY REQUIREMENTS.—

(1) IN GENERAL.—Notwithstanding any provision of section 514 of the Employee Retirement Income Security Act of 1974 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supercede any provisions of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of section 2705A.

(2) CLARIFICATIONS.—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual insurance market or to small employers (as such term is defined for purposes of section 2705A(d)).

[(c)**]***(e)* RULES OF CONSTRUCTION.—* * *

[(d)**]***(f)* DEFINITIONS.—For purposes of this section—

(1) STATE LAW.—* * *

* * * * * * *

○